

State of Maine Health Plan

(Actives, Non-Medicare Retirees and Ancillary Groups)
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

Effective Date: 07-01-2012
Aetna Choice™ POS II - ASC

Primary Care Physician Benefit Level				
BENEFITS	PREFERRED		REFERRED	SELF REFERRED
Calendar Year Deductible	Individual	\$300	\$1,500	\$2,500
	Family	\$600	\$3,000	\$5,000
Coinsurance	95% unless otherwise noted		80% unless otherwise noted	60% unless otherwise noted
Maximum Annual Out-of-Pocket	Individual	\$1,100	\$3,000	\$5,000
(per calendar year)	Family	\$2,200	\$6,000	\$10,000
(Includes deductibles and coinsurance)				
Lifetime Maximum			Unlimited	
Primary Care Physician Selection			Required	
Precertification penalty for certain procedures/treatments - Out of Network \$500 per occurrence.				
Referral Requirement	Yes		Yes	None
PREVENTIVE CARE	PREFERRED		REFERRED	SELF REFERRED
Routine Adult Physical Exams/ Immunizations	100%, \$0 Copay		100%, \$0 Copay	Not Covered
Routine Well Child Exams/Immunizations	100%, \$0 Copay		100%, \$0 Copay	Not Covered
Routine Gynecological Care Exams	100%, \$0 Copay		100%, \$0 Copay	100%, \$0 Copay
	Includes routine tests and related lab fees			Not Covered
Routine Mammograms	100% No Deductible			
Routine Eye Exam	100% after \$0 copay			
One routine eye exam pers calendar year up to age 19, adults 65 and over, and people with diabetes. All other adults, one every two years.				
Routine Digital Rectal Exam / Prostate-specific Antigen Test 1 Annual No Age Limit	100% No Deductible			Not Covered
Colorectal Cancer Screening (also includes medically necessary)	100% No Deductible- Copay waived			60% After Deductible
PHYSICIAN SERVICES	PREFERRED		REFERRED	SELF REFERRED
Office Visits to PCP	\$0 copay		\$20 Copay	60% after self referred deductible
Specialist Office Visits	\$25 Copay		\$25 Copay	60% after self referred deductible
Maternity OB Visits	\$25 Copay 1st visit only		\$25 Copay 1st visit only	60% after self referred deductible
Allergy Testing	Covered at applicable PCP or Specialist Office Visit. Independent lab covered at plan co-insurance after deductible		Covered at applicable PCP or Specialist Office Visit. Independent lab covered at plan co-insurance after deductible	60% after self referred deductible
Allergy Injections	100% after preferred deductible			60% after self referred deductible
Hearing- diagnostic and surgical services received during office visit	100% after \$25 specialist copay			60% after self referred deductible
NON HOSPITAL	PREFERRED		REFERRED	SELF REFERRED
Ambulatory Surgery Facility	85% after preferred level deductible			60% after self referred deductible
Diagnostic Laboratory and X-ray	85% after preferred level deductible			
High Tech Diagnostic/Complex Imaging- (MRI, CT Scan, PET Scan)	100% after \$50 copay			

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EMERGENCY, URGENT CARE, WALK IN CENTERS, AMBULANCE	PREFERRED		REFERRED	SELF REFERRED
Urgent Care Provider	100% after \$100 copay, waived if admitted			
Emergency Room	100% after \$100 copay, waived if admitted			
Walk In Centers	100% after \$25 specialist copay			60% after self referred deductible
Ambulance	100% after preferred deductible			
HOSPITAL CARE & SERVICES	PREFERRED		REFERRED	SELF REFERRED
Inpatient Coverage	95% after preferred deductible	80% after referred deductible	60% after self referred deductible	
Inpatient Maternity Coverage	100% after preferred deductible			60% after self referred deductible
Outpatient Ambulatory Surgery	95% after preferred deductible	80% after referred deductible		60% after self referred deductible
Outpatient Laboratory tests and X-ray	95% after preferred deductible	80% after referred deductible		
Outpatient Hospital Expenses (excluding surgery)	95% after preferred deductible	80% after referred deductible		60% after self referred deductible
OTHER SERVICES	PREFERRED		REFERRED	SELF REFERRED
Audiology	100% after \$25 specialist copay			60% after self referred deductible
Acupuncture	80% after \$25 specialist copay			50% after self referred deductible
Pulmonary Rehabilitation	95% after deductible	80% after referred deductible		60% after self referred deductible
Nutritional Counseling	100% after preferred deductible			60% after self referred deductible
Convalescent Facility (Skilled Nursing) <i>Limit 100 days in a calendar year</i>	100% after preferred deductible			60% after self referred deductible
Home Health Care	100% after preferred deductible			
Hospice Care - Inpatient	100% after preferred deductible			60% after self referred deductible
Hospice Care - Outpatient	100% after preferred deductible			60% after self referred deductible
Outpatient Short-Term Rehabilitation	100% after \$25 copay			60% after self referred deductible
Outpatient Speech, Physical & Occupational Therapy	100% after \$25 copay			60% after self referred deductible
Spinal Manipulation Therapy (Chiropractic)	100% after \$25 copay			60% after self referred deductible
Durable Medical Equipment	100% after preferred deductible			60% after self referred deductible
Custom Molded Shoe Inserts for Members with Diabetes	80% after preferred level deductible			50% after self referred deductible
Prosthetics (Excluding Limbs)	100% after preferred deductible			60% after self referred deductible
Prosthetics for Limb Replacement	100% after preferred deductible			80% (deductible does not apply)
MENTAL HEALTH & SUBSTANCE ABUSE	PREFERRED		REFERRED	SELF REFERRED
Inpatient	95%, no deductible			60% after self referred deductible
Day Treatment	100% no deductible			60% after self referred deductible
Outpatient	95%, no deductible			60% after self referred deductible
Hospital Emergency Room	100% after \$100 copay			
Office Visits	100% after \$0 PCP or \$25 Specialist Copay	100% after \$20 PCP or \$25 Specialist Copay		60% after self referred deductible
Health Care Services	100% no deductible			60% after self referred deductible
FAMILY PLANNING	PREFERRED		REFERRED	SELF REFERRED
Infertility Treatment- Services (for example, diagnostic and surgical services) received during or associated with an office visit or services ordered or rendered by a professional or provider may be subject to the applicable coinsurance and deductible (in addition to the copayment)	80% after preferred deductible			not covered
Maximum Per Lifetime	\$20,000			
GENERAL PROVISIONS				
Dependents Eligibility	Spouse, children from birth to age 26			

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PHARMACY - PRESCRIPTION DRUG BENEFITS

Retail

For 30 Day Supply: \$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs, and \$45 copay for non-formulary brand-name and generic drugs at participating pharmacies. Infertility and Impotence Drugs: \$50 copay for up to 30 day supply.
For 90 Day Supply: \$15 copay for formulary generic drugs, \$45 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name and generic drugs. Infertility and Impotence Drugs: \$75 copay for up to a 90 day supply.

Mail Order

For 30 Day Supply: \$10 copay for formulary generic drugs, \$30 copay for formulary brand-name drugs and \$45 copay for non-formulary brand-name drugs. Infertility and Impotence Drugs: \$50 copay for up to 30 day supply.
For 90 Day Supply: \$15 copay for formulary generic drugs, \$45 copay for formulary brand-name drugs, and \$70 copay for non-formulary brand-name and generic drugs up to a 31-90 day supply from Aetna Rx Home Delivery®. Infertility and Impotence Drugs: \$75 copay for a 90 day supply.